



North Carolina  
Department of Health and Human Services  
Division of Medical Assistance  
Medical Policy

1985 Umstead Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501  
Courier Number 56-20-06

Michael F. Easley, Governor  
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr. M.D., Assistant Secretary  
for Health Policy and Medical Assistance

**Certification of Need: Medicaid Inpatient Psychiatric Services Under Age 21**

Recipient Name: \_\_\_\_\_ Hospital: \_\_\_\_\_

Medicaid ID # \_\_\_\_\_ Provider # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Admission Date: \_\_\_\_\_

**Type of Certification:** (check 1 item)

\_\_\_\_\_ Pre-admission/elective

\_\_\_\_\_ Emergency admission

**Medicaid Eligibility Status:** (check 1 item)

\_\_\_\_\_ Medicaid eligible on admission

\_\_\_\_\_ Pending Medicaid on admission

\_\_\_\_\_ **No evidence of Medicaid on admission**

\_\_\_\_\_ Applied for Medicaid during stay

\_\_\_\_\_ Applied for Medicaid after discharge

**At the time of admission, the interdisciplinary team certifies the following:**

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
3. The acute inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

\_\_\_\_\_  
Physician Team Member Signature

\_\_\_\_\_  
Print name/Title

\_\_\_\_\_  
Date (Mo/Day/Yr)

\_\_\_\_\_  
Other Team Member Signature

\_\_\_\_\_  
Print name/Title

\_\_\_\_\_  
Date (Mo/Day/Yr)

Submit to:

ValueOptions  
P.O. Box 13907  
5001 South Miami Boulevard  
Suite 200  
RTP, NC 27709

*Revised 11/21/05*